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# Euthanasia: Murder or Mercy?

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Euthanasia has become one of the most urgent issues of our times. This has come about because of the development of technology that has enabled us to sustain our existence far beyond the "natural" course of life. Sometimes this extension of life involves an improvement of the functioning and the well-being of the patient. Not infrequently, though, it is only the dying process that is extended. The question this has forced upon us in the modern age, especially in the last several decades, is whether there is a point at which death is kinder than life. This is the issue of euthanasia, how we die: when, where, by what means, in whose presence, and by whose authority.

In dealing with this issue, it is advisable to declare one's personal involvement. Mine began in the first year of my ministry some 22 years ago. An older woman told me that she wanted to die. She was weary of pain and helplessness. She felt diminished by being a care-receiver rather than a care-giver. Life had no pleasure or purpose for her other than pain relief. She was without hope. She wanted the release of death, and was not even able to help herself to accomplish this. It took eight years of misery for her yearning to become reality. My efforts to comfort her were futile, even, as I look back now, cruel.

More recently I was involved with a congregant, Merian Frederick, who sought out the services of Dr Jack Kevorkian. On October 22, 1993 Merian took her life in Royal Oak, Michigan, in the presence of her son and daughter-in-law, Dr Kevorkian, and myself. Her choice was made after a struggle of several years with ALS (Lou Gehrig's Disease) and with the awareness that she would soon lose her only means of communicating with the world, the strength in her fingers to write her thoughts on a yellow pad or tap out a message on her computer.

I had known Merian for 12 years, worked with her in many capacities in the church, and counseled with her and her family on many personal issues. We had discussed euthanasia theoretically for many years before she first experienced the symptoms of ALS. Within a few days of her being diagnosed, that conversation became very practical and very personal. As her spiritual counselor, I worked with her to be sure that every possible option was considered and then considered again. Her family was intimately involved in this conversation and in the eventual decision which Merian made.

Had there been a better way for Merian to be relieved of what she viewed as pure hell—a good mind soon to be unable to communicate because of the ruined body in which it was housed—she would have chosen it. Having made her choice, she spent the last days of her life more happily and more purposefully than at any time since learning the name and nature of her disease.

One lesson from this experience is that suffering is easier to bear if there is a known terminal point to it.

Two decades ago I felt helpless before a woman's request. Two years ago I was able to be helpful, though doing so meant a certain minor amount of legal risk. In between these benchmark experiences and after the second one, I have had many occasions to confront this issue of how we die. These experiences and much study and reflection have led me to support the moral right of

competent adult persons at the end of their lives to choose death over continued suffering, and to seek the help of professionals and of loved ones in ending their lives if that is necessary.

I support euthanasia.

Like most individuals and most religions, I support passive euthanasia, allowing someone to die without taking heroic measures to save them.

Like a growing number of individuals but almost no religion except Unitarian Universalism, I also support active euthanasia, the right of a person to seek and obtain competent help to end a life that has become or soon will be unbearable.

If we choose active euthanasia, we should have the best available help to make the terminal point of life truly good and gentle for us. This may call for professionals in health care, like doctors and nurses. It may mean family or close friends. It may mean both.

We should not die in great agony or with doubt about whether we shall succeed in ending our lives or with concern for those who have helped us to die. We should die without pain, with certainty that death does await us as a relief from our suffering, and with confidence that our loved ones and care-givers will not be legally threatened because of their kindness to us.

If loved ones and professionals are able to cooperate with us, the moment of our death can be truly full of love.

At this time I am not prepared to defend such a choice for children, for non-competent adults, or for those who are comatose who have not given explicit instruction prior to their becoming unconscious.

## Five principles guide my thinking and my acting

### First, mere existence is not an absolute value.

That which exists changes, grows, deteriorates, becomes something quite different. Value is found more in the process than in the simple existence of any form of life. Conscious and articulate life, human life, sometimes can choose its changes, grounding that choice in values and meanings derived from its own life experiences. Sometimes the change that is made is death, an end to this existence being preferable to a continuation of it.

Every one of the religions and philosophies which have had major influence on our society argues this way. Socrates believed that death was better than violating the law of the city. Jews perished at Masada rather than be enslaved. Christians martyred themselves rather than betray their god by bowing to a Roman deity.

There are ideals, values, principles, and persons for which and for whom we would give up our lives if called upon to do so. What parent would not sacrifice their own life to save the life of their child? There are people who risk their lives, and sometimes lose them, in rescuing a stranger.

By making such a choice as this, we are at least implicitly saying that our death helps someone who is left behind. In certain circumstances, we may regard that way of helping another as being of higher value than our own existence.

To choose death sooner rather than later, actively rather than passively, can be an act of high moral stature.

Mere existence is not an absolute value.

**The second principle is that we should respect life.**

We should rejoice in life and be glad that we are alive. We should not give up life cheaply or quickly, our own or others. We should live as fully as we can for as long as we can. But there are different ways of doing this.

My friend Pansy respected life by defying her doctors when they declared that her 96 year old kidneys had shut down and were not going to function again. Three months after this diagnosis, she went home. She went back to her purposeful work of calling people who were house-bound or in nursing homes and hospitals to cheer them up. She kept this up until her energies gave out one year later and she died.

The Pitney VanDusens also respected life. They loved each other over many years. They made a pact as part of that love that they would die together. When both were of advanced age, and one of them was in very poor health, one day they simply lay down on their marital bed and he took her life and then his own. They made it clear that they did not wish to live under conditions in which they could not give but only take, conditions in which they would only be a burden to others, conditions in which they could only suffer. It was time for them to move on. They respected life by ending it and making room for someone else to enjoy life.

Sometimes choosing to die is as much a sign of respecting life as choosing to live.

**A third principle is that suffering in and of itself has no moral worth.**

Religions (like Christianity; see Augustine, Aquinas, et al) that include in their teaching the idea that the deity gives us pain in order to help us grow spiritually or to chastise us for our sinfulness are missing the moral mark. How could anyone have confidence in a deity who would cause the kind of suffering that one can see daily in hospitals, nursing homes, and emergency rooms. My experience as a chaplain at the Massachusetts Hospital School for Handicapped Children revealed to me the enormous suffering through which some children must go. The various ailments of these youngsters were not the consequence of their moral failings. They were simply damnably bad luck. I could not imagine a divine figure who would bring such anguish to these gutsy boys and girls and their families. That they redeemed their suffering with courage and humor and hard work did not make me or them grateful for their pain and disability. It only made me and others more appreciative of their endurance and their achievements.

Suffering that we have not chosen does not in and of itself have any moral value. Disease, accident, decline, great age do not themselves have moral worth. How we face them does. One ethical way of doing that is by choosing not to let that suffering continue when it is of such magnitude that nothing else in life matters and there is no hope of relief save in death.

Suffering is not itself moral. Only our response to it can be moral.

**The next principle is this: the autonomy of each individual must be respected.**

Within the constraints of time and place and ability, each of us can choose how to live and each of us should be allowed to choose how we die. It is not that we have a right to die, as though there were an alternative to dying we must somehow resist. It is that, if death does not surprise us, we have a right to choose the moment of our letting go.

Autonomy is essential in moral action. Autonomy means that we are informed about the conditions in which we find ourselves and that we have legitimate options between which to choose. Autonomy does not mean that we are coerced subtly or overtly into one decision or another. It means that we freely make the choice we deem best.

Autonomy is necessary if we are to have meaning as moral creatures. It must be as applicable in our waning days and hours as it is when we are in full strength.

**The fifth principle is that our individual lives are imbedded in community.**

It is in the connections that we make to others that the deepest layers of meaning in our lives are revealed. We make these connections with families, friends, colleagues, neighbors, people who share our religious or political outlook or who enjoy the same sport or hobby. We also make connections with people who are different from us and who in their difference call upon us to enlarge our vision of the human collective.

In all the major decisions of our living, thinking about and sharing with a wider network of associations is important for understanding the larger meaning of what we are choosing to do.

This is especially true when it comes to decisions about ending our lives. It is of great importance that we begin **now** to talk with those we care about regarding our feelings about death and dying. How long do we wish to live when our condition is terminal and our suffering great? Such talk helps us to know the impact of our decisions about how we want to die on those who survive us. In loving relationships, this knowledge may sometimes, and rightly, influence the choices we make.

Preparing Advance Medical Directives and a Durable Power of Attorney helps to clarify our views at this moment. Such documents announce to loved ones and strangers how we wish to confront our own ending. Together with conversation, these papers help others to understand, even if they do not agree with us, why we have made the decision we have made.

Death and dying are in one sense the most individual and isolating events of our lives. But in another sense these moments are very communal. The dying and death of any person we love touches us, changes us, alters the way life is for us.

The presence at memorial services of physicians, nurses, and other health care workers and care-givers testifies to the fact that those who are with us professionally in our last days are also part of our community.

No one is an island. The death of any of us affects all who know that person. How that death occurs is often as significant as the fact of death.

We live and we die in community.

These five principles are the basis of my support for passive and active euthanasia.

That support is not without an awareness of concerns raised by opponents of active euthanasia. Some of these concerns have more validity than others.

The concern that seems most valid to me is that when you move the line of what is permitted, you also sometimes move the line of what is expected. There is a danger that if active euthanasia (aid in dying) were legal, some who would not otherwise do so might be subtly coerced into choosing to end their lives.

It is easy to imagine a situation in which a member of a family that is already under great stress is given a particularly grim prognosis. However loving the discussion with that person may be, she may come to feel that dying sooner rather than later is what everyone really wants, even if that is not what she desires. Her choice of death

in this situation may not really be her choice.

Financial pressures, the burdens of care, the example of others can all conspire innocently to push a person towards a decision he or she might not really want to make. We must be very careful how we frame laws and how we construct systems of aid in dying so as to minimize the chances of this happening.

A second concern that merits attention is the present structure of health care in this country. It is a vast commercialized bureaucracy—actually it is a mess of competing bureaucracies with more than 1500 insurance companies, thousands of hospitals, and governments at Federal, state, and local levels—with mountains of paper work, endless delays, complicated rules and regulations that defy comprehension, unintelligible jargon, and expenses that boggle the imagination.

The system appears to be designed to make insurance companies wealthy, doctors very comfortable but also very frustrated, and those of us who need medical attention consumers and not patients, as though freedom of choice were more important than competent medical care for every person in the country.

It is hard to believe that such a sensitive issue as aid in dying would not be cheapened by the institutional processes by which Americans now must struggle to be treated for their ills. How many forms in triplicate will we have to fill out? How long will we have to wait for approval of our request? How long must we linger while insurance clerks decide if active euthanasia is covered by our policy?

For the sake of those whose suffering brings them to decide on active euthanasia, we must be sure that neither greed nor an indifferent bureaucracy gets in the way.

Other concerns about aid in dying are less meritorious.

One of these concerns is that by allowing aid in dying, programs in pain management and care programs like hospice will lose money and support. Nothing that I have ever read or heard from proponents of assisted suicide argues that this should or will be done. There is room for many approaches to dying, from the care-oriented attitudes of hospice to palliative pain prescription by a physician in a hospital to aggressive cure-oriented treatment by research doctors to assistance in gently ending a life.

Most people who support active euthanasia also support increased degrees of pain medication to keep people truly comfortable. The problem has been with the refusal of some and the reluctance of other physicians to do this.

Another dimension to this is the fact that not all pain can be managed. What right has any of us, much less society at large, to force people to endure grievous pain that cannot be relieved short of total unconsciousness with no hope that this can be changed? If a person in such a condition pleads for death, as many of us might do, by what moral standard do we continue to refuse to give them the help they are begging for?

A kind system of health care would recognize that different people will make different choices in these agonizing circumstances. A kind system of health care would make provision for all possible choices: risky experimental procedures, hospice care, adequate pain management, and aid in dying for those who choose it.

One other major concern raised by opponents of active euthanasia is that to make aid in dying legal we will be asking doctors to be killers as well as healers. Doctors, it is argued, cannot be both. Doctors, it is argued, must not violate the Hippocratic Oath which many of them have taken upon graduation from medical school. Since Do No Harm is part of that oath, helping someone to end their life is a violation of the Oath because death ends life and therefore is harmful.

Those who rely on the Hippocratic Oath read it selectively. They do not, for example, also call upon modern doctors to swear by the

ancient gods dear to Hippocrates. They do not have protest marches outside of operating rooms, even though Hippocrates said that "I will not use the knife."

More important than arguments about how to interpret ancient documents is the simple fact that doctors cannot always be healers. Each of us will come to a point in life when no medical treatment will help us, save perhaps to relieve our pain. At that point, when our condition is terminal, what we need more than anything else is intelligent compassion. We need people who understand the pain in our bodies and the suffering in our souls.

Compassion may well be to give us drugs and apply therapies to make our bodies feel better. But for some of us, compassion may well be to help ease us into death.

Doctors already do this, and do it legally and with the support of most religious communities. What they do is act under the principle of the double effect. The double effect is the principle by which doctors prescribe for pain even though they know that the level of medication prescribed will kill the patient.

This is a kindness for those whose bodies are racked with pain, whose spirits are sore with despair, who have no realistic hope this side of the grave, and who want relief from the pain. They want out of life. It is a kindness for the families who suffer watching helplessly as their loved ones writhe in agony.

What I do not understand is why aid in dying is not also a kindness when performed with the full conscious participation of the dying person who has made repeated requests to die. To know that I can choose the moment that my anguish will be no more is to re-create hope within me. The only moral difference I can see between aid in dying and the double effect is that in the former it is the patient who is in control, who chooses the when and the where and the with whom, while in the latter it is the physician who is in control.

Morally the double effect and aid in dying are the same. In both cases, the patient, the families, and the doctor know that death will be the direct consequence of the actions taken. Indeed, that is the desired consequence. It is scandalous to me that the double effect is legal and aid in dying is a criminal act.

Ultimately the issue of how we die is a spiritual issue, not a medical or legal one. Religion has a vital role to play in this issue, though sadly many religious leaders have not been willing to assume that role.

Part of that role is to be a spiritual counselor to those who are confronted by death. Our task is to help people to think clearly about the options available. Our task is to give full emotional, moral, and spiritual support to whatever decision the person before us makes. Our responsibility is to be with people, not tell them what they must do or judge them because their decisions do not agree with ours.

Furthermore it is important for us to be a dynamic part of the societal conversation that is taking place right now. The best way we can do this is by discussing the issue as rationally as we are able to do, by encouraging discussion among our congregants and others, by writing and speaking and being active in seeking legislation that will defend a point of view consistent with our religious understanding.

Margaret Battin of the University of Utah some years ago was suggesting that churches and synagogues were likely going to be centers through which individuals would come to engage a physician who would assist them to die. She cited the work of many religious communities in the 1960s and early 1970s in helping

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you want this treatment or not?"

Most people are taken care of in the home; patients and families generally prefer this to institutionalization. Making use of community resources during this period is great help to both the family and physician. A hospice program is extremely beneficial. Often hospice is equated with cancer care; however the same philosophy applies to any endstage condition, such as advanced dementia or Parkinson's disease. A hospice can provide skilled nursing services; nurses aid services, respite care, social services as well as coverage for medications and certain supplies. Nursing services are especially helpful in working with the physician to modulate medications for pain.

Patients at this point rarely fear death itself. They fear more the potential of having pain and suffering during the dying process. Unfortunately, many patients do not have these fears addressed and do not receive the necessary medications to relieve their pain. A recent article in the *New England Journal of Medicine* describes this well. Adequate treatment of pain in terminal conditions is not given sufficient attention for many reasons: lack of education, inappropriate concern about the effects of narcotics to name two. Concern about addiction in a patient with a terminal illness really approaches the absurd.

Depression as a co-morbid condition in a chronic disease and terminal illness is also under recognized and treated. Depressive symptoms are often dismissed as being an accepted part of the condition thus not meriting attention. In many cases an antidepressant can be very beneficial in improving the quality of life and as an adjunct to treating pain.

The following illustrates a "best case scenario." An 80-year-old man with endstage Parkinson's Disease and dementia is cared for at home by his wife and a hired caregiver. The physician makes routine home visits to provide support and guidance in the day to day care. As the disease progresses, the patient develops symptoms of dysphagia. Discussions between the wife and physician on previous occasions have led to the decision not to tube feed or do other aggressive measures. As the dysphagia represents a significant change in the prognosis, a referral to Hospice is made to assist with the terminal care. The physician prescribes liquid morphine to have on hand in the event of respiratory distress probably due to aspiration. Visits are made by both the hospice nurse and the physician to provide additional support. The wife is instructed to give as much morphine as is necessary to relieve the respiratory distress. After several days, the patient passes away quietly at home with the wife during the days that follow. A much preferred passing to what could have happened without adequate preparation: years of meaningless existence in vegetative state with a feeding tube in a nursing home.

The need for this kind of care will only grow in the future. Physicians can and should play such an important part in the care of dying patients. Despite the availability of excellent paraprofessionals, patients and families ultimately look to the physician for real guidance and decision-making. There is so much to do medically during the dying process: aggressive relief of pain, aggressive treatment of depression, aggressive use of community resources. Being at the bedside of a dying patient, if to do nothing else but listen, can be the greatest practice of the art of medicine.

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women to find doctors who would perform abortions in those days before *Roe vs. Wade*. Battin saw religious institutions as the right place for people to come. A religious community is the only place whose central focus is the meaning and value of life, and the disturbing fact of death which challenges all claims to meaning and value.

The work of Ralph Mero and others clearly indicates that some of our clergy are hearing the call to respond to those suffering people in need of aid in dying. Such work is to be highly commended and extended by others of us as we are able.

The ultimate goal is to enable every person not carried away by sudden death to make informed choices about what happens to them in the last stages of life. We will not all choose the same way. There must be room for those who choose to live even in the face of frightful pain and suffering and for those who choose an earlier point of death.

The Greeks gave us the word euthanasia. It is a lovely word that means simply, good death. Only if we are given the full legal right to make the choice of how we shall die, and to get the assistance of our physicians in carrying out that choice—for existence to continue by every means possible or for death to take us out of our misery—does the good death, euthanasia, become possible for all of us. It is my hope that every person will be able to have a good death.

#### Editor's Note:

Ken Phifer now serves as Senior Minister at First Unitarian Universalist Church in Ann Arbor. He received a B.A. in history at Harvard and attended the University of Chicago Divinity School. He served as Scholar in Residence at the Ecumenical Institute for Jewish Christian Studies, as well as teacher, advisor and Minister at several institutions on the mainland. But, Ken Phifer has firm connections to Hawaii: he taught at Mid-Pacific Institute, has lectured at the Pali Unitarian Church and his parents live in Hawaii at Pohai Nani. Mahalo, Ken for sharing your words of compassion with us.

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